TITLE XIX

Grants to States for Medical Assistance Programs

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS[1] AND RELATED PROVISIONS OF P.L. 92–603, P.L. 93–66, and P.L. 93–233

Appropriation

Sec. 1901.[2] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals,[3] whose income and re-

[1] This title is administered by the Social and Rehabilitation Services Administration, Department of Health, Education, and Welfare. Regulations of the Secretary of Health, Education, and Welfare relating to this title are contained in chapter II, title 45, Code of Federal Regulations.

See footnote to sec. 1 of title I for provisions of the Civil Rights Act of 1964 affecting federally assisted programs.

P.L. 90–248, sec. 234(c), provides:

"(c) Notwithstanding any other provisions of law, after June 30, 1968, no Federal funds shall be paid to any State as Federal matching under title I, X, XIV, XVI, or XIX of the Social Security Act for payments made to any nursing home for or on account of any nursing home services provided by such nursing home for any period during which such nursing home is determined not to meet fully all requirements of the State for licensure as a nursing home, except that the Secretary may prescribe a reasonable period or periods of time during which a nursing home which has formerly met such requirements will be eligible for payments which include Federal participation if during such period or periods such home promptly takes all necessary steps to again meet such requirements."

P.L. 92–603, sec. 402, provides:

"In order for a State to be eligible for any payments pursuant to title IV, V, XVI, or XIX of the Social Security Act with respect to expenditures for any quarter in the fiscal year ending June 30, 1975, and for the purpose of providing an orderly transition from State to Federal administration of the Supplemental Security Income Program, such State shall enter into an agreement with the Secretary of Health, Education, and Welfare under which the State agencies responsible for administering or for supervising the administration of the plans approved under titles I, X, XIV, and XVI of the Social Security Act will, on behalf of the Secretary, administer all or such part or parts of the program established by section 301 of this Act, during such portion of the fiscal year ending June 30, 1975, as may be provided in such agreement."

[2] P.L. 93–233, section 13(d) made changes in section 1901 and 1902 effective with respect to payments under Section 1903 of the Act for calendar quarters commencing after December 31, 1973.

[3] P.L. 93–233, section 13(a)(1) struck "permanently and totally" which preceded "disabled" in the first sentence of section 1901 to reflect establishment of the Supplemental Security Income Program and conformance with the title XVI definition of disability.

sources are insufficient to meet the cost of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

State Plans for Medical Assistance

Sec. 1902.[1] (a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 percentum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, super-

[1] P.L. 93–233, section 13(d) made changes in sections 1901 and 1902 effective with respect to payments under section 1903 of the Act for calendar quarters commencing after December 31, 1973.

vision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the plan approved under title I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI, or by the agency or agencies administering the Supplemental Security Income Program established under title XVI or the State plan approved under part A of title IV if the State is not eligible to participate in the State plan program established under title XVI;[1]

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportu-

[1] P.L. 93–233, section 13(a) (2) (B) amended 1902(a) (5) to take account of the Supplemental Security Income Program. Under the old public assistance titles of the Act, Medicaid eligibility determinations had to be made by the same agency administering the State's cash assistance program for the aged. Since the State plan programs now exist only in Guam, Puerto Rico and the Virgin Islands, all States—pursuant an amendment by P.L. 93–233, section 13(a)(2)(A)—have flexibility in designating an appropriate agency or agencies to make eligibility determinations.

nity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purposes specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions;[1]

(10) provide—[2]

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI;[3]

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the Supplemental Security Income Program under title XVI, as the case may

[1] P.L. 92-603, section 239(a) revised section 1902(a)(9) in its entirety. Effective January 1, 1973 (or earlier if the State plan so provides). Previously, section 1902 (a) (9) read: "(9) provide for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;".

[2] P.L. 93-233, Section 13 made the necessary technical changes in 1902(a)(10) to take account of the Supplemental Security Income Program under which receipt of Medicaid is no longer dependent upon receipt of cash assistance.

[3] States which do not elect to return to their 1972 medical assistance eligibility standards are required to provide Medicaid coverage to individuals receiving Federal Supplemental Security Income benefits.

be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them Supplemental Security Income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State

supplementary payment[1] shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);[2]

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan; and (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments for part or all of the cost of plans or projects under title V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under title V and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made

[1] States have the option to provide coverage for categories of individuals receiving or eligible to receive State supplementary payments.

[2] P.L. 92–603, as amended by P.L. 93–66, provides persons eligible for receiving cash under the public assistance titles of the Social Security Act for the month of August 1972 are grandfathered into continued Medicaid coverage to July 1975 if they are terminated from cash assistance as a result of the 20 percent Social Security benefit increase provided by P.L. 92–336. See Section 249E (as amended by Section 233 of P.L. 93–66) of P.L. 92–603 in addendum.

P.L. 93–233 requires States to continue Medicaid eligibility for individuals receiving mandatory State supplementary payments. See Section 13(c) of P.L. 93–233 in addendum.

P.L. 93–66 provides that any individual eligible for medical assistance in December 1973 as an essential person continues to be eligible as long as the individual with whom such person is living continues to meet the criteria in effect for December 1973 for aid or assistance under a State plan and the essential spouse relationship is maintained according to the December 1973 State plan. See Section 230 of P.L. 93–66 in addendum.

P.L. 93–66, as amended by P.L. 93–233, provides for continued Medicaid eligibility for those blind and disabled persons who were in December 1973 eligible for medical assistance on the basis of their blindness or disability but who do not meet the new title XVI definitions of blindness or disability provided they meet the other eligibility conditions of the current plan. See Section 232 of P.L. 93–66 in addendum.

P.L. 93–66, as amended by P.L. 93–233, provides that individuals in medical institutions in December 1973 who would have been eligible for assistance under a State plan approved under title I, X, XIV, or XVI, except for the fact that they were inpatients (or whose special needs as inpatients make them eligible for assistance) will retain their Medicaid eligibility as long as there is a continuing need for care for the condition or conditions for which they were institutionalized and continuing eligibility for financial assistance under the approved State plan under title I, X, XIV or XVI in effect in December 1973. See Section 231 of P.L. 93–66 in addendum.

to the State with respect to him under section 1903;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A)(i) for the inclusion of some institutional and some non-institutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing home services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and[1]

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905(a) or

(ii)(I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122,[2] which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of

[1] P.L. 93–233, section 13(a)(4) made the necessary technical change in 1902(a)(13)(B) to take account of the Supplemental Security Income Program.

[2] P.L. 92–603, section 221(c)(5), inserted ", consistent with section 1122,". Effective October 30, 1972.

any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII;[1] and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost-related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary;[2]

(14) effective January 1, 1973, provide that—

(A) in case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI, or who meet the income and resources requirements of the appropriate State plan, or the Supplemental Security Income Program under title XVI, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10) (A)—[3]

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in clauses (1) through (5) and (7) of section 1905(a), will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount

[1] P.L. 92-603, section 232(a), revised section 1902(a)(13)(D) in its entirety. Effective July 1, 1972, or earlier if the State plan so provides. Previously, section 1902(a)(13)(D) read: "(D) for payment of the reasonable cost (as determined in accordance with standards, approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan:".

[2] P.L. 92-603, section 249(a), added section 1902(a)(13)(E).

[3] P.L. 93-233, section 13(a)(5) made the necessary technical change in 1902(a)(14)(A) to take account of the Supplemental Security Income Program.

(as determined in accordance with standards approved by the Secretary and included in the plan), and

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)) who are not receiving aid or assistance under any such State plan and with respect to whom Supplemental Security Income benefits are not being paid under title XVI and who do not meet the income and resources requirements of the appropriate State plan, or the Supplemental Security Income Program under title XVI, as the case may be,[1]

(i)[2] there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal; [3]

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such title is not met, the portion thereof which is met shall be determined on a basis reasonably

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[1] P.L. 93–233, section 13(a)(6) made technical changes in 1902(a)(14)(B) to take account of the Supplemental Security Income Program. States retain their option to cover the medically needy in their medical assistance programs.

[2] P.L. 93–368 changed this from "shall" to "may" thus making such fees and charges optional with State Agencies.

[3] P.L. 92–603, section 208(a), amended section 1902(a)(14) in its entirety. Effective January 1, 1973 or earlier if the State plan so provides. Previously, section 1902(a)(14) read: "(14) provides that (A) in the case of individuals receiving aid or assistance under State plans approved under titles I, X, XIV, XVI, and part A of title IV, no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to inpatient hospital services furnished him under the plan, and (B) any deduction, cost sharing, or similar charge imposed under the plan with respect to inpatient hospital services or any other medical assistance furnished to an individual thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, shall be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or his income and resources;".

related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom Supplemental Security Income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient, and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under a State plan approved under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him Supplemental Security Income benefits under title XVI as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program);

and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;[1]

(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program) of any medical assistance correctly paid on behalf of such individual under the plan;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate

[1] P.L. 93-233, section 13(a)(7) amended 1902(a)(17) to take account of the Supplemental Security Income Program.

plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution;

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in 3(a) (4) (A) (i) and (ii), or section 603(a)(1)(A)(i) and (ii), or section 1603 (a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for

establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality; and

(23) provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization;[1]

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this Act, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this Act, and (C) to provide information needed to determine payments due under this Act on account of care and services furnished to individuals;

[1] P.L. 92-603, Section 240, added "and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization;". Paragraph (23) of section 1902(a), pursuant to P.L. 90-248, sec. 227(b), as amended by P.L. 92-603, section 271(a) effective from and after July 1, 1972, applies in the case of Puerto Rico, the Virgin Islands, and Guam only with respect to calendar quarters beginning after June 30, 1975.

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(26) effective July 1, 1969, provide (A) for a regular program of medical review (including medical evaluation) of each patient's need for skilled nursing facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility; (B) for periodic inspections to be made in all skilled nursing facilities and mental institutions (if the State plan includes care in such institutions) within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) or (i) the care being provided in such nursing facilities (and mental institutions, if care therein is provided under the State plan) to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities (or institutions), (iii) the necessity and desirability of the continued placement of such patients in such nursing facilities (or institutions), and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections together with any recommendations to the State agency administering or supervising the administration of the State plan;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency with such information, regarding any payments claimed by such persons or institution for providing services under the State plan, as the State agency may from time to time request;

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j), except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this title;[1]

(29) include a State program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes;

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4))[2] as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

(31) provide (A) for a regular program of independent professional review (including medical evaluation of each patient's need for intermediate care) and a written plan of service prior to admission or authorization of benefits in an intermediate care facility[3] as determined under regulations of the Secretary; (B) for periodic on-site inspections to be made in all such intermediate care facilities (if the State plan includes care in such institutions) within the State by one or more independent professional review teams (com-

[1] P.L. 92-603, section 246(a), revised section 1902(a)(28) in its entirety. Effective July 1, 1973.

[2] P.L. 92-603, section 237(a)(2), inserted "(including but not limited to utilization review plans as provided for in section 1903(i)(4))". Effective July 1, 1973.

[3] P.L. 92-603, section 298, deleted "which provides more than a minimum level of health care services".

posed of physicians or registered nurses and other appropriate health and social service personnel) of (i) the care being provided in such intermediate care facilities to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular intermediate care facilities to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities, (iii) the necessity and desirability of the continued placement of such patients in such facilities, and (iv) the feasibility of meeting their health care needs through alternative institutional or non-institutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections, together with any recommendations to the State agency administering or supervising the administration of the State plan;[1]

(32) provide that no payment under the plan for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;[2]

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of

[1] P.L. 92-223, section 4(b), added section 1902(a)(31), effective January 1, 1972.
[2] P.L. 92-603, section 236(b), added section 1902(a)(32). Effective January 1, 1973, or earlier if the State plan so provides.

the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan;[1]

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such asistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application[2] (or application was made on his behalf in the case of a deceased individual[3]) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) effective January 1, 1973, provide that any intermediate care facility receiving payments under such plan must supply to the licensing agency of the State full and complete information as to the identity (A) of each person having (directly or indirectly) an ownership interest of 10 per centum or more in such intermediate care facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such intermediate care facility or any of the property or assets of such intermediate care facility,[4] (B) in case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and (C) in case an intermediate

[1] P.L. 92–603, section 239(b), added section 1902(a)(33). Effective January 1, 1973, or earlier if the State plan so provides.

[2] P.L. 92–603, section 255(a), added section 1902(a)(34). Effective July 1, 1973.

[3] P.L. 93–233, section 18(o), added parenthetical provision, effective July 1, 1973, pursuant to section 18(Z)(4) of P.L. 93–233.

[4] P.L. 93–233, section 18(p) expanded 1902(a)(35) to include persons who own obligations secured by the assets of an institution.

care facility is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied;[1] and

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.[2]

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)).

For purposes of paragraph (9)(A), (29), (31), and (33), and of section 1903(i)(4), the term "skilled nursing facility" and "nursing home" do not include a Christian Science sanatorium

[1] P.L. 92-603, section 299A, added section 1902(a)(35).
[2] P.L. 92-603, section 299D(b), added section 1902(a)(36).

operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.[1]

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes as a condition for eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 406(a)(2), be a dependent child under part A of subchapter IV of this chapter; or

(3) any residence requirement which excludes any individual who resides in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this title, attributable to medical needs)[2] provided for eligible individuals under a plan of such State approved under title I, X, XIV, or XVI, or part A of title IV.

(d) (Repealed).[3]

(e) Notwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calen-

[1] P.L. 92–603, section 268(a), added the last sentence of section 1902(a). Effective as of October 30, 1972.

[2] P.L. 91–56, sec. 2(c), enacted August 9, 1969, inserted "in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this title, attributable to medical needs)" in lieu of "(other than so much of the aid or assistance as is provided for under the plan of the State approved under this title)".

[3] P.L. 92–603, sec. 231, repealed sec. 1902(d).

dar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.[1]

(f) Notwithstanding any other provision of this title, except as provided in subsection (e), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any Supplemental Security Income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom Supplemental Security Income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10)(C) of that subsection, an individual who is eligible for medical assistance

[1] P.L. 92-603, section 209(a), added section 1902(e). P.L. 93-233, section 18(q) modified the extension of Medicaid eligibility for certain AFDC recipients.

by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection.[1]

Payment to States

Sec. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter beginning with the quarter commencing January 1, 1966

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (h) of this section)[2] of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof);[3] plus

[1] P.L. 92–603, section 209(b)(1), added section 1902(f). Effective January 1, 1974. P.L. 93–233, section 13(a)(10) amended 1902(f) to take account of the new Supplemental Security Income Program; section 13(a)(10)(C) substituted "as defined in section 213 of the Internal Revenue Code of 1954" with "as recognized under State law;" section 13(a)(10)(D) modified the language of 1902(f) to clarify that States have the option to return to their January 1, 1972 medical assistance standard for purposes of determining Medicaid eligibility and that persons who enter the program through the spend-down are considered categorically needy in States which do not have medically needy programs.

[2] P.L. 92–603, section 207(a)(2), inserted ", subject to subsections (g) and (h) of this section". Effective July 1, 1973.

[3] P.L. 93–233, section 13(a)(11) amended section 1903(a)(1) to take account of the Supplemental Security Income Program; section 18(r)(1) amended 1903(a)(1) to limit Federal payments for expenditures related to the disabled eligible under title XVIII.

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency; plus

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed $150,000), and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operations of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan of the specific services so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments

made under the plan on account of the services; plus[1]

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus[2]

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies,[3]

(6) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1)[4] Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969,[5] shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).[6]

(2) For limitation on Federal participation for capital ex-

[1] P.L. 92–603, section 235(a), added section 1903(a)(3). Applicable to expenditures under State plans approved under title XIX made after June 30, 1971.

[2] P.L. 92–603, section 249B, added section 1903(a)(4). Effective for the period beginning October 1, 1972, and ending June 30, 1974. P.L. 93–233, section 18(s) amended 1903(a)(4) to clarify that 100 percent Federal matching is for costs incurred rather than sums expended between October 1, 1972 and June 30, 1974. This was further extended to June 30, 1977 by P.L. 93–368.

[3] P.L. 92–603, section 299E(a), added section 1903(a)(5). P.L. 93–233, section (18)(t) amended 1903(b)(5) to clarify that Federal payment for family planning expenditures is not limited to administrative costs.

[4] P.L. 92–603, section 295, repealed former section 1903(b)(1).

[5] P.L. 90–364, sec. 303(a)(1), enacted June 28, 1968, inserted "1969" in lieu of "1967".

[6] P.L. 93–233, section 18(r)(2) placed a limitation on payments to States for expenditures in relation to disabled individuals eligible for title XVIII. P.L. 93–233, section 18(z-3)(4) made the effective date of this provision July 1, 1973. P.L. 93–233, section 18(u) amended 1903(b)(2) to include an exception to the limitation on payments to States.

penditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.[1]

(c) (Repealed).[2]

(d) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(e) (Repealed).[3]

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[1] P.L. 92-603, section 221(c)(6), added section 1903(b)(2).

[2] P.L. 93-233, sec. 18(y)(1)(A) repealed sec. 1903(c).

[3] P.L. 92-603, section 230, repealed section 1903(e). Former section 1903(e) read: "(e) The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by June 1, 1977, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."

(f) (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133-1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan (without regard to section 408) provided for aid to such a family.

(4)[1] The limitations on payment imposed by the preceding pro-

[1] P.L. 93-233, section 13(a)(12) amended 1903(f) to take account of the Supplemental Security Income Program.

visions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual—

(A) who is not receiving aid or assistance under any plan of the State approved under title I, X, XIV, XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the Supplemental Security Income benefit rate established by section 1611(b)(1), at the time of the provision of the medical assistance giving rise to such expenditure.[1]

(g)(1) With respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased by 33-1/3 per centum thereof unless the State

[1] P.L. 93-233, section 13(a)(12) amended 1903(f)(4) to allow States the option of covering as categorically needy, institutionalized persons by deeming them in need of a supplementary payment, and therefore Medicaid, on the basis that they would need cash assistance if they were outside of the institution, if their income is within 300 percent of the Supplemental Security Income level.

agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—

(A) in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days, and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

(B) in each such case, such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(C) such State has in effect a continuous program of review of utilization pursuant to section 1902(a)(30) whereby the necessity for admission and the continued stay of each patient in such institution is periodically reviewed and evaluated (with such frequency as may be prescribed in regulations of the Secretary) by medical and other professional personnel who are not themselves directly responsible for the care of the patient or financially interested in any such institution or, except in the case of hospitals, employed by the institution;[1] and

(D) such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to section 1902(a) (26) and (31) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams.

[1] P.L. 93-233, section 18(v) amended 1903(g)(1)(C) to exempt hospitals from the requirement that review of the utilization of institutional care be performed by individuals not employed by the institution involved.

In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.[1]

(h)(1) If the Secretary determines for any calendar quarter beginning after June 30, 1973, with respect to any State that there does not exist a reasonable cost differential between the statewide average cost of skilled nursing facility services and the statewide average cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures under the State plan by any amount which in his judgment is a reasonable equivalent of the difference between the amount of the expenditures by such State for intermediate care facility services and the amount that would have been expended by such State for such services if there had been a reasonable cost differential between the cost of skilled nursing facility services and the cost of intermediate care facility services.

(2) In determining whether any such cost differential in any State is reasonable the Secretary shall take into consideration the range of such cost differentials in all States.

(3) For the purposes of this subsection, the term "cost differential" for any State for any quarter means, as determined by the Secretary on the basis of the data for the most recent calendar quarter for which satisfactory data are available, the excess of—

(A) the average amount paid in such State (regardless of the source of payment) per inpatient day for skilled nursing facility services, over

(B) the average amount paid in such State (regardless of the source of payment) per inpatient day for intermediate care facility services.

(4) For purposes of this subsection, the term "cost" shall mean amounts reimbursable by the State under a State plan approved

[1] P.L. 92-603, section 207(a)(1), added section 1903(g). Effective July 1, 1973.

under this title.[1]

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b)(3); or[2]

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2); or[3]

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or[4]

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing home has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this para-

[1] P.L. 92-603, section 207(a)(1), added section 1903(h). Effective July 1, 1973.
[2] P.L. 92-603, section 224(c), added section 1903(i)(1).
[3] P.L. 92-603, section 229(c), added section 1903(i)(2).
[4] P.L. 92-603, section 233(c), added section 1903(i)(3). Applicable to services furnished by hospitals in accounting periods beginning after December 31, 1972.

graph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).[1]

(j)[2](1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any institution during any period that an order for suspension of payment (as authorized by this subsection) is effective with respect to such institution.

(2) The Secretary may issue a suspension of payment order with respect to any institution if—

(A) such institution (i) does not (at the time such order is issued) have in effect an agreement with the Secretary which is entered into pursuant to section 1866; and (ii) did (prior to the time such order is issued) have in effect such an agreement; and

(B)(i) The Secretary has been unable to collect (or make satisfactory arrangement for the collection of) amounts due on account of overpayments made to such institution under title XVIII; or

(ii) the Secretary has been unable to obtain from such institution the data and information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII.

(3) Whenever the Secretary issues any order for suspension of payment under this subsection with respect to any institution, he shall submit a notice of such order to the single State agency (referred to in section 1902(a)(5) of each State which he has reason to believe does or may utilize the services of such institution in providing medical assistance under a plan approved under this title.

(4) Any order for suspension of payment issued with respect to any institution under this subsection shall become effective, in the case of any State plan approved under this title, on the 60th day after the date the State agency (referred to in section 1902(a)(5)) administering or supervising the administration of such plan re-

[1] P.L. 92–603, section 237(a)(1), added section 1903(i)(4).

[2] P.L. 92–603, section 225 added another section 1903(j) which limited the allowable increase in average per diem payments for skilled nursing facility and intermediate care facility services, and which was repealed by P.L. 93–66, Section 234(a). Effective for skilled nursing services and for intermediate care facility services furnished in calendar quarters which begin after December 31, 1972, as per P.L. 93–66, section 234(b).

ceives notice of such order submitted pursuant to paragraph (3). Any such order shall cease to be effective at such time as the Secretary is satisfied that the institution is participating in substantial negotiations which seek to remedy the conditions which gave rise to his order of suspension of payments, or that the amounts (referred to in paragraph (2) are no longer due from such institution or that a satisfactory arrangement has been made for the payment by such institution of any such amounts. Upon the determination of the Secretary that any such order with respect to any such institution shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under paragraph (3) with respect to such institution.

(5) Whenever any order which has been issued by the Secretary under the preceding provisions of this subsection with respect to an institution ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such institution shall be made to such State for the month in which such order ceases to be effective.[1]

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any health maintenance organization which meets the requirements of section 1876 for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.[2]

Operation of State Plans

Sec. 1904. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments

[1] P.L. 92-603, section 290, added a second section 1903(j).

[2] P.L. 92-603, section 226(e), added section 1903(k). Applicable to services provided on or after June 1, 1973.

will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

Definitions

Sec. 1905.[1] For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom Supplemental Security Income benefits are not being paid under title XVI, who are

(i) under the age of 21,[2]

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child, except for section 406(a)(2), is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind; with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

[1] P.L. 93-233, section 13(a)(13) amended 1905(a) to take account of the Supplemental Security Income Program.

[2] The 1965 Amendments to the Social Security Act broadened the Kerr-Mills program to make eligible for medical assistance, all needy children under 21 regardless of their categorical relatedness.

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,[1] or

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) outpatient hospital services;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older; (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;[2]

(5) physicians' services furnished by a physician (as defined in section 1861(r)(1))[3], whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

[1] See Section 230 of P.L. 93–66 in addendum.

[2] P.L. 92–603, sec. 299E(b), added sec. 1905(a)(4)(C).

[3] P.L. 92–603, sec. 280, inserted "furnished by a physician (as defined in section 1861(r)(1))".

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;[1]

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;[2]

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h); and

(17) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16)[3], such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases,

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual.

[1] P.L. 92–603, sec. 297(a), revised sec. 1905(a)(14) in its entirety. Applicable to services furnished after December 31, 1972. Previously, sec. 1905(a)(14) read: "(14) inpatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;".

[2] P.L. 92–223, sec. 4(a)(1), added sec. 1905(a)(15). Effective January 1, 1972.

[3] P.L. 92–603, section 299B(c) inserted "except as otherwise provided in paragraph (16)," in lieu of "except that".

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1110(a)(8).

(c) For purposes of this title the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, and (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes under State law. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. The term "intermediate care facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of clauses (2) and (3) of this subsection and providing the care and services required under clause (1). With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d), any public institution or distinct part thereof

for mental diseases or mental defects.[1]

(d) The term "intermediate care facility services" may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) The primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and which meet such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

(3) the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.[2]

(e) In the case of any State the State plan of which (as approved under this title)—

(1) does not provide for the payment of services (other than services covered under section 1902(a)(12)) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term "physicians' services" (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to

[1] P.L. 92-223, sec. 4(a)(2), added sec. 1905(c) except the next to the last sentence. Effective January 1, 1972. P.L. 92-603, section 299L(a), added the next to the last sentence of section 1905(c).

[2] P.L. 92-223, sec. 4(a)(2), added sec. 1905(d). Effective January 1, 1972. P.L. 92-603, section 299, revised section 1905(d)(3) in its entirety. Previously, section 1905(d)(3) read: "(3) the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures with respect to patients in such institution (or distinct part thereof) will not be reduced because of payments made under this title."

perform, and shall be reimbursed whether furnished by a physician or an optometrist.[1]

(f) For purposes of this title, the term "skilled nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.[2]

(g) If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1861(r)(5); and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.[3]

(h)(1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary,[4] and (ii) a team, consisting of physicians and other personnel qualified to make determination with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (A) the date such individual attains age

[1] P.L. 92–603, section 212(a), added section 1905(e). Applicable to services performed after October 30, 1972.

[2] P.L. 92–603, section 247(b), added section 1905(f). Applicable to services furnished after December 31, 1972.

[3] P.L. 92–603, section 275(a), added section 1905(g). Applicable to services furnished after June 30, 1973.

[4] P.L. 93–233, section 18(w) amended 1905(h)(1)(B) to give the Secretary authority under title XIX to establish standards for the active treatment of mental illness.

21, or (B) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (i) the date such individual no longer requires such services, or (ii) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State and the political subdivisions thereof, from non-Federal funds for such services.[1]

(i) For purposes of this title, the term "skilled nursing facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as being a qualified skilled nursing facility by meeting the requirements of section 1861(j).[2]

(j) The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving Supplemental Security Income benefits under title XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Secretary), but only to the extent that such payments are made with respect to an individual with respect to whom Supplemental Security Income benefits are payable under title XVI, or would but for his income be payable under that title.[3]

(k) Increased Supplemental Security Income benefits payable pursuant to section 211 of P.L. 93–66 shall not be considered Supplemental Security Income benefits payable under title XVI.[4]

Sec. 1906. [Repealed.][5]

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[1] P.L. 92–603, section 299B(b), added section 1905(h).
[2] P.L. 92–603, section 299L(b), added a second section 1905(h) which P.L. 93–233 redesignated as subsection (i).
[3] P.L. 93–233, section 13(a) (18) added subsection (j) to 1905.
[4] P.L. 93–233, section 13(a) (18) added subsection (k) to 1905.
[5] P.L. 92–603, section 287(a), repealed section 1906. Effective January 1, 1973.

Observance of Religious Beliefs

Sec. 1907. Nothing in this title shall be construed to require any State which has a plan approved under this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

State Programs for Licensing of Administrators of Nursing Homes

Sec. 1908. (a) For purposes of section 1902(a)(29), a "State program for licensing of administrators of nursing homes" is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

(b) Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purpose of this section.

(c) It shall be the function and duty of such agency or board to—

(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and re-

voke or suspend licenses previously issued by the board in any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

(d)[1] No State shall be considered to have failed to comply with the provisions of section 1902(a)(29) because the agency or board of such State (established pursuant to subsection (b)) shall have granted any waiver, with respect to any individual who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1902 (a)(29) are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such agency or board pursuant to subsection (c).[2]

(e) As used in this section, the term—

(1) "nursing home" means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts [3]; and

(2) "nursing home administrator" means any individual

[1] P.L. 92–603, section 269, inserted the first sentence of section 1908(d).

[2] P.L. 93–233, section 18(y)(3) deleted obsolete provisions following the first sentence of 1908(d) and redesignated subsection (g) as subsection (e).

[3] P.L. 92–603, section 268(b), inserted, "but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts". Effective on October 30, 1972.

who is charged with the general administration of a nursing home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.

Penalties[1]

Sec. 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State plan approved under this title and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

[1] P.L. 92-603, section 242(c), added section 1909. Does not apply to any acts, statements, or representations made or committed before October 30, 1972.

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months or both.

Certification and Approval of Skilled Nursing Facilities[1]

Sec. 1910. (a) Whenever the Secretary certifies an institution in a State to be qualified as a skilled nursing facility under title XVIII, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902(a)(28).

(b) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any institution which has applied for certification by him as a qualified skilled nursing facility.

[1] P.L. 92-603, section 249(a), added section 1910. Applicable to agreements filed with the Secretary under section 1866 by skilled nursing facilities before, on, or after October 30, 1972, but accepted by him after that date.

Related Provisions of the Social Security Act, P.L. 92–603, P.L. 93–66, and P.L. 93–233

Section 1108 of the Act (Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam) as amended by Section 271 of Public Law 92–603)

Public Law 92–603

Sec. 249E Determining Eligibility for Assistance under Title XIX for Certain Individuals (as amended by Section 233 of P.L. 93–66)

Sec. 221
Limitation on Federal Participation for Capital Expenditures

Sec. 249C
Disclosure of Information Concerning the Performance of Carriers, Intermediaries, State Agencies, and Providers of Services Under Medicare and Medicaid

Sec. 249D
Limitation on Institutional Care

Sec. 299E
Family Planning Services Mandatory Under Medicaid

Sec. 299F
Penalty for Failure to Provide Child Health Screening Services Under Medicaid

Public Law 93–66

Sec. 230
Coverage of Essential Persons Under Medicaid

Sec. 231 (as amended by section 13(b)(1) of P.L. 93–233)
Persons in Medical Institutions

Sec. 232 (as amended by section 13(b)(2) of P.L. 93–233)

Public Law 93–233

Sec. 13C
Medical Eligibility for Persons Receiving Mandatory State Supplementary Payments

Excerpt from the Social Security Act

Section 1108 Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam (as amended by Section 271 of P.L. 92–603, which provided an increase in the limitation on Payments to Puerto Rico and the Virgin Islands for Medical Assistance.)

Sec. 1108. (a) The total amount certified by the Secretary of Health, Education, and Welfare under title I, X, XIV, and XVI, and under part A of title IV (exclusive of any amounts on account of services and items to which subsection (b) applies)—

(1) for payment to Puerto Rico shall not exceed—

(A) $12,500,000 with respect to the fiscal year 1968,

(B) $15,000,000 with respect to the fiscal year 1969,

(C) $18,000,000 with respect to the fiscal year 1970,

(D) $21,000,000 with respect to the fiscal year 1971,

or

(E) $24,000,000 with respect to the fiscal year 1972 and each fiscal year thereafter:

(2) for payment to the Virgin Islands shall not exceed—

(A) $425,000 with respect to the fiscal year 1968,

(B) $500,000 with respect to the fiscal year 1969,

(C) $600,000 with respect to the fiscal year 1970,

(D) $700,000 with respect to the fiscal year 1971, or

(E) $800,000 with respect to the fiscal year 1972 and each fiscal year thereafter: and

(3) for payment to Guam shall not exceed—

(A) $575,000 with respect to the fiscal year 1968,

(B) $690,000 with respect to the fiscal year 1969,

(C) $825,000 with respect to the fiscal year 1970,

(D) $960,000 with respect to the fiscal year 1971, or

(E) $1,100,000 with respect to the fiscal year 1972 and each fiscal year thereafter.

(b) The total amount certified by the Secretary under part A of title IV, on account of family planning services and services provided under section 402(a)(19) with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exceed $2,000,000,

(2) for payment to the Virgin Islands shall not exceed $65,000, and

(3) for payment to Guam shall not exceed $90,000.

(c) The total amount certified by the Secretary under title XIX with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exceed $30,000,000,

(2) for payment to the Virgin Islands shall not exceed $1,000,000, and

(3) for payment to Guam shall not exceed $900,000.

(d) Notwithstanding the provisions of section 502(a) and 512 (a) of this Act, and the provisions of sections 421, 503(1), and 504(1) of this Act as amended by the Social Security Amendments of 1967, and until such time as the Congress may by appropriation or other law otherwise provide, the Secretary shall, in lieu of the initial allotment specified in such sections, allot such smaller amounts to Guam, American Samoa, and the Trust Territory of the Pacific Islands as he may deem appropriate.

Excerpt From the Social Security Amendments of 1972 as modified by Public Law 93–66 (Section 233)

DETERMINING ELIGIBILITY FOR ASSISTANCE UNDER TITLE XIX FOR CERTAIN INDIVIDUALS

Sec. 249E. For purposes of section 1902(a)(10) of the Social Security Act any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act and who for such month was entitled to monthly insurance benefits under title II of such Act shall be deemed to be eligible for such aid or assistance for any month thereafter prior to July 1975 if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under title II of such Act resulting from enactment of Public Law 92–336 not been applicable to such individual.

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Excerpt from Social Security Amendments of 1972
Public Law 92–603

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Section 221(a) Title X. of the Social Security Act is amended by adding at the end thereof the following new section.

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

"SEC. 1122. (a) The purpose of this section is to assure that Federal funds appropriated under titles V, XVIII, and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities or health maintenance organizations which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests) will—

"(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility or health maintenance organization in such State within the field of its responsibilities,

(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities or health maintenance organizations in such State within the fields of their respective responsibilities, and

"(3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted an opportunity for a fair hearing by such agency or person other than the designated agency as the Governor (or other chief executive officer) may designate to hold such hearings, whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

"(c) The Secretary shall pay any such State from the Federal Hospital Insurance Trust Fund, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

"(d)(1) Except as provided in paragraph (2), if the Secretary determines that—

"(A) neither the planning agency designated in the agreement described in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

"(B) (i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency had responsibility, and

"(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b)—

"(I) consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility or health maintenance organization proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions, and

"(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure. With respect to any organization which is reimbursed on a per capita basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita basis.

"(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility or health maintenance organization would discourage the operation or expansion of such facility or organization, or of any facility of such organization, which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration

of title V, XVIII, or XIX, he shall not include such expenses pursuant to paragraph (1).

"(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

"(f) Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

"(g) For the purpose of this section, a 'capital expenditure' is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000.

"(h) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

"(i) (1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this Act or under other Federal or federally assisted health programs.

"(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under paragraph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

"(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meet-

ings of the council or otherwise serving on business of the council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS–18 in section 5332 of title 5, United States Code, including traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of such title 5 for persons in the Government service employed intermittently."

(b) The amendment made by subsection (a) shall apply only with respect to a capital expenditure the obligation for which is incurred by or on behalf of a health care facility or health maintenance organization subsequent to whichever of the following is earlier: (A) December 31, 1972, or (B) with respect to any State or any part thereof specified by such State, the last day of the calendar quarter in which the State requests that the amendment made by subsection (a) of this section apply in such State or such part thereof.

(c)(1) Section 505(a)(6) of such Act (as amended by section 232(b) of this Act) is further amended by inserting ", consistent wth section 1122," after "standards" where it first appears.

(2) Section 506 of such Act (as amended by sections 224(d), 229(d), 233 (d), and 237(b) of this Act, is further amended by adding at the end thereof the following new subsection:

"(g) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

(3) Clause (2) of the second sentence of section 509(a) of such Act is amended by inserting ", consistent with section 1122," after "standards".

(4) Section 1861(v) of such Act is amended by adding at the end thereof the following new paragraph:

"(5) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

(5) Section 1902(a)(13)(D) of such Act (as amended by section 232(a) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(6) Section 1903(b) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

(d) In the case of a health care facility providing health care services as of December 18, 1970, which on such date is committed to a formal plan of expansion or replacement, the amendments made by the preceding provisions of this section shall not apply with respect to such expenditures as may be made or obligations incurred for capital items included in such plan where preliminary expenditures toward the plan of expansion or replacement (including payments for studies, surveys, designs, plans, working drawings, specifications, and site acquisition, essential to the acquisition, improvement, expansion, or replacement of the health care facility or equipment concerned) of $100,000 or more, had been made during the three-year period ended December 17, 1970.

Public Law 92–603
Excerpt From the Social Security Amendments of 1972

DISCLOSURE OF INFORMATION CONCERNING THE PERFORMANCE OF CARRIERS, INTERMEDIARIES, STATE AGENCIES, AND PROVIDERS OF SERVICES UNDER MEDICARE AND MEDICAID

SEC. 249C. (a) Section 1106 of the Social Security Act is amended by adding at the end thereof the following new subsections:

"(d) Notwithstanding any other provision of this section the Secretary shall make available to each State agency operating a program under title XIX and shall, subject to the limitations contained in subsection (e), make available for public inspection in readily accessible form and fashion, the following official reports (not including, however, references to any internal tolerance rules and practices that may be contained therein, internal working papers or other informal memoranda) dealing with the operation of the health programs established by titles XVIII and XIX—

"(1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews;

"(2) comparative evaluations of the performance of such contractors, including comparisons of either overall performance or of any particular aspect of contractor operation; and

"(3) program validation survey reports and other formal evaluations of the performance of providers of services, including the reports of follow-up reviews, except that such reports shall not identify individual patients, individual health care practitioners, or other individuals.

"(e) No report described in subsection (d) shall be made public by the Secretary or the State title XIX agency until the contractor or provider of services whose performance is being evaluated has had a reasonable opportunity (not exceeding 60 days) to review such report and to offer comments pertinent parts of which may be incorporated in the public report; nor shall the Secretary be required to include in any such report information with respect to any deficiency (or improper practice or procedures) which is known by the Secretary to have been fully corrected, within 60 days of the date such deficiency was first brought to the attention of such contractor or provider of services, as the case may be."

(b) The provisions of subsection (a) shall apply with respect to reports which are completed by the Secretary after the third calendar month following the enactment of this Act.

LIMITATION ON INSTITUTIONAL CARE

SEC. 249D. Section 121(b) of the Social Security Amendments of 1965 is amended by adding at the end thereof the following new sentence: "After the date of enactment of the Social Security Amendments of 1972, Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act, if such care is (or could be) provided under a State plan approved under title XIX of such Act by an institution certified under such title XIX.".

(This provision in effect for State plans under titles, I, X, XIV and Part A of title IV. Section 14 of P.L. 93–233 parallels this provision for aged, blind and disabled persons where the Supplemental Security Income Program is in effect.)

FAMILY PLANNING SERVICES MANDATORY UNDER MEDICAID

SEC. 299E. (a) Section 1903(a) of the Social Security Act, as amended by sections 235 and 249B of this Act, is further amended by redesignating paragraph (5) as paragraph (6), and by inserting after paragraph (4) the following new paragraph:

"(5) an amount equal to 90 per centum of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the plan) which are attributable to the offering, arranging and furnishing (directly or on a contract basis) of family planning services and supplies;".

(b) Section 1905(a)(4) of the Social Security Act is amended by adding after clause (B) the following: "and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;".

(c) Section 402(a)(15)(B) of such Act is amended, effective January 1, 1973, (1) by adding after "in all appropriate cases" the following: "(including minors who can be considered to be sexually active)", and (2) by adding after "family planning services are offered them" the following: "and are provided promptly (directly or under arrangements with others) to all individuals voluntarily requesting such services".

(d) Section 403 of such Act is amended by adding at the end thereof the following new sections:

"(e) Notwithstanding any other provision of subsection (a), with respect to expenditures during any calendar quarter beginning after December 31, 1972 (as found necessary by the Secretary for the proper and efficient administration of the plan) which are attributable to the offering, arranging, and furnishing, directly or on a contract basis, of family planning services and supplies, the amount payable to any State under this part shall be 90 per centum of such expenditures.

"(f) Notwithstanding any other provision of this section, the amount payable to any State under this part for quarters in a fiscal year shall with respect to quarters in fiscal years beginning after June 30, 1973, be reduced by 1 per centum (calculated without regard to any reduction under section 403(g)) of such amount if such State—

"(1) in the immediately preceding fiscal year failed to carry out the provisions of section 402(a)(15)(B) as pertain to requiring the offering and arrangement for provision of family planning services; or

"(2) in the immediately preceding fiscal year (but, in the case of the fiscal year beginning July 1, 1972, only considering the third and fourth quarters thereof), failed to carry out the provisions of section 402(a)(15)(B) of the Social Security Act with respect to any individual who, within such period or periods as the Secretary may prescribe, has been an applicant for or recipient of aid to families with dependent children under the plan of the State approved under this part."

PENALTY FOR FAILURE TO PROVIDE CHILD HEALTH SCREENING SERVICES UNDER MEDICAID

SEC. 299F. Section 403 of the Social Security Act is amended by adding at the end thereof the following:

"(g) Notwithstanding any other provision of this section, the amount payable to any State under this part for quarters in a fiscal year shall with respect to quarters in fiscal years beginning after June 30, 1974, be reduced by 1 per centum (calculated without regard to any reduction under section 403(f) of such amount if such State fails to—

"(1) inform all families in the State receiving aid to families with dependent children under the plan of the State approved under this part of the availability of child health screening services under the plan of such State approved under title XIX,

"(2) provide or arrange for the provision of such screening services in all cases where they are requested, or

"(3) arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services."

Excerpt From Public Law 93–66

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COVERAGE OF ESSENTIAL PERSONS UNDER MEDICAID

SEC. 230. In the case of any State plan (approved under title XIX of the Social Security Act) which for December 1973 provided medical assistance to persons described in section 1905(a)(vi) of such Act, there is hereby imposed the requirement (and such State plan shall be deemed to require) that medical assistance under such plan be provided to each such person (who for December 1973 was eligible for medical assistance under such plan) for each month (after December 1973) that—

(1) the individual (referred to in the last sentence of section 1905(a) of such Act) with whom such person is living continues to meet the criteria (as in effect for December 1973) for aid or assistance under a State plan (referred to in such sentence), and

(2) such person continues to have the relationship with such individual described in such sentence and meets the other criteria (referred to in such sentence) with respect to a State plan (so referred to) as such plan was in effect for December 1973.

Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.

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Section 231 (As amended by section 13(b)(1) of P.L. 93–233)

PERSONS IN MEDICAL INSTITUTIONS

SEC. 231. For purposes of section 1902(a)(10) of the Social Security Act, any individual who, for all (or any part of) the month of December 1973—

(1) was an inpatient in an institution qualified for reimbursement under title XIX of the Social Security Act, and

(2)(A) received or would (except for his being an inpatient in such institution) have been eligible to receive aid or assistance under a State plan approved under title I, X, XIV, or XVI of such Act, and

(B) on the basis of his status as described in subparagraph (A), was included as an individual eligible for medical assistance under a State plan approved under title XIX of such Act (whether or not such individual actually received aid or assistance under a State plan referred to in subparagraph (a)),

shall be deemed to be receiving such aid or assistance for such month and for each succeeding month in a continuous period of months if, for each month in such period—

(3) such individual continues to be (for all of such month an inpatient in such an institution and would (except for his being an inpatient in such institution) continue to meet the conditions of eligibility to receive aid or assistance under such plan (as such plan was in effect for December 1973), and

(4) such individual is determined (under the utilization review and other professional audit procedures applicable to State plans approved under title XIX of the Social Security Act) to be in need of care in such an institution.

Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.

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Section 232 (As amended by section 13(b)(2) of P.L. 93–233)

BLIND AND DISABLED MEDICALLY INDIGENT PERSONS

SEC. 232. For purposes of section 1902(a)(10) of the Social Security Act, any individual who, for the month of December 1973 was eligible for medical assistance by reason of his having been determined to meet the criteria for blindness or disability (established by a State plan approved under title I, X, XIV, or XVI of such Act), shall be deemed for purposes of title XIX to be an individual who is blind or disabled within the meaning of section 1614(a) of the Social Security Act for each month in a continuous period of months (beginning with the month of January 1974), if, for each month in such period, such individual continues to meet the criteria for blindness or disability so established by such a State plan and the other conditions of eligibility contained in the plan of the State approved under title XIX (as it was in effect in December 1973). Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.

MEDICAID ELIGIBILITY FOR INDIVIDUALS RECEIVING MANDATORY STATE SUPPLEMENTARY PAYMENTS

(c) In addition to other requirements imposed by law as conditions for the approval of any State plan under title XIX of the Social Security Act, there is hereby imposed (effective January 1, 1974) the requirement (and each such State plan shall be deemed to require) that medical assistance under such plan shall be provided to any individual—

(1) for any month for which there (A) is payable with respect to such individual a supplementary payment pursuant to an agreement entered into between the State and the Secretary of Health, Education, and Welfare under section 212(a) of Public Law 93–66, and (B) would be payable with respect to such individual such a supplementary payment, if the amount of the supplementary payments payable pursuant to such agreement were established without regard to paragraph (3)(A)(ii) of such section 212(a), and

(2) in like manner, and subject to the same terms and conditions, as medical assistance is provided under such plan to individuals with respect to whom benefits are payable for such month under the Supplementary Security Income Program established by title XVI of the Social Security Act.

Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals who are eligible for such assistance under this subsection.

PAYMENTS TO SUBSTANDARD FACILITIES UNDER MEDICAID

SEC. 14. Section 1616 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(e) Payments made under this title with respect to an individual shall be reduced by an amount equal to the amount of any supplementary payment (as described in subsection (a)) or other payment made by a State (or political subdivision thereof) which is made for or on account of any medical or any other type of remedial care provided by an institution to such individual as an inpatient of such institution in the case of any State which has a plan approved under title XIX of this Act if such care is (or could be) provided under a State plan approved under title XIX of this Act by an institution certified under such title XIX.".

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